Family Medicine and Community Health

The role of the primary healthcare research community in addressing the social and structural determinants of health: a call to action from NAPCRG 2023

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ABSTRACT

The need for effective primary healthcare to address social and structural determinants of health and to mitigate health inequalities has been well established. Here, we report on the international forum of the 2023 NAPCRG (formerly known as North American Primary Care Research Group) Annual Meeting. The aim of the forum was to develop principles for action for the primary healthcare research community on addressing social and structural determinants of health. From this forum, 10 key recommendations for the primary care research community were identified.

INTRODUCTION

Primary care is a critical component of healthcare systems around the world. While primary care is generally medically focused, broader conceptualisations, in particular primary healthcare (PHC), take a public health approach.[1–3] The WHO Commission on Social Determinants of Health revived the understanding of health as a social phenomenon, requiring more complex forms of inter-sectoral policy action. The social determinants of health cover a wide range of topics, including gender differences and gender discrimination, undernutrition and overnutrition, social support and social exclusion, and other socioeconomic, political, cultural and environmental factors. The WHO framework for action on social determinants of health represented a paradigm shift in policy by their inclusion in the health system.[4] As a result, the role of primary care in addressing the social (and structural) determinants of health (SDOH) has become an important focus of primary care policy, research, education and practice, and should be one of the key commitments of the PHC research community.

NAPCRG (formerly known as the North American Primary Care Research Group) is a global organisation that focuses on high-quality primary care research.[5] The members of NAPCRG are based in all regions of the world and include clinician-researchers, primary care scientists, policymakers, consumer and community members. Each year, NAPCRG gathers together at the Annual Meeting to share, learn and discuss the current issues in international primary care research and advocacy. One of the recurring themes of NAPCRG Annual Meetings has been SDOH and the place of primary care in improving health equity within our communities.

The 2023 NAPCRG Annual Meeting was attended by approximately 1000 delegates. The NAPCRG International Committee facilitated an international forum focused on SDOH using a world café approach.[6] Approximately 35 participants from different parts of the world (North America, The Caribbean, Europe, Oceania) attended the forum. During the forum, the WEAR (Workforce, Education, Advocacy and Research) framework was used to debate the role of primary healthcare practitioners in addressing SDOH.[7] The WEAR framework has been used by the Deep End GP movement in Scotland which has an overarching aim to reduce health inequity.[8]

In this paper, we synthesise the forum discussions according to the WEAR framework, and we propose 10 recommendations

Box 1 10 ways that the primary healthcare research community can demonstrate our commitment to responding to the structural and social determinants of health.

1. Support a multidisciplinary primary healthcare team approach
2. Develop workforce strategies for a representative primary healthcare workforce
3. Embed a social accountability approach in healthcare training programmes
4. Develop spiral curricula that upskill the workforce and that span 'whole of career'
5. Remove barriers for under-represented groups in health training programmes
6. Undertake cultural humility and structural competency training
7. Use networks to raise awareness of SDOH
8. Develop and use resources and training to foster advocacy
9. Prioritise social determinants of health in primary healthcare research
10. Build community partnerships and collaborate in primary healthcare research

(Box 1) for addressing the SDOH that could be used by the global PHC research community.

Patient and Public Involvement

As an organisation, NAPCRG prioritises patient and public involvement. Patient partners are encouraged to attend the annual meeting. NAPCRG also has the patient and clinician engagement (PaCE) committee (https://napcrg.org/programs/pace/) which actively promotes patient-engaged research, and has a scheme to support patient partner attendance at the annual meeting at reduced rates. All attendees at the NAPCRG annual meeting were eligible to participate in the international forum described here. There were members of NAPCRG who are community members and patients in attendance at the forum.

Workforce

Ensuring an appropriate PHC workforce is an important part of the WHO declaration of Astana[9] that states that the PHC workforce is required to be 'safe, of high quality, comprehensive, efficient, acceptable, available and affordable, and will deliver continuous, integrated services that are people-centred and gender-sensitive'.[9] Workforce-related recommendations include:

1. Comprehensive PHC should ideally be delivered by a multidisciplinary team.[10] Workforce planning for team-based PHC requires an understanding of population needs and a matching of the competencies possessed by different members of the team to the identified needs of the community.[11] Population needs include social and psychological domains, as well as health domains and require intersectoral activity, advocacy, and the integration of community healthcare and personal care so that they can be addressed.[12]
2. Develop workforce retention strategies for a representative PHC workforce. Key elements of these strategies include workplace support, education initiatives, community and family engagement, community health workers, financial incentives and health services redesign.[13]

Education

Addressing the workforce challenges, described above, requires a strategic and proactive approach to health professional education. Education recommendations include:

3. Delivering continuous, integrated services that are 'people-centred and gender-sensitive'[9] can be challenging in traditional training models. To address this challenge, a social accountability approach was suggested. Social and cultural accountability requires healthcare training institutions to identify social needs and challenges in the communities that they serve, to adapt their programmes to meet these challenges and to measure the impact of their programmes and the benefit on society.[14] Trainees who undertake programmes that have implemented social accountability generally are more representative of their communities.[15]
4. The need to take a whole career perspective—considering the training needs from undergraduate teaching to postgraduate training to lifelong learning. This should follow best practice for spiral curricula, with a focus on building and learning through community-based placements, incorporating emerging lessons from inclusion health and trauma-informed care and with involvement of 'experts by experience'.[16]
5. Recognising the need to remove barriers for under-represented groups. These groups experience health inequalities, often at the intersections of marginalisation (eg, minoritised ethnicities, Indigenous peoples). For example, adjustments in work expectations and roles could allow people with more diverse abilities (eg, physical abilities, neurodiversity) to become doctors.[17]
6. The need for healthcare professionals to have 'cultural competency'—the mastery of measurable skills, knowledge, attitudes and behaviours for practitioners to become self-aware of their own culture and those of diverse populations and how one might influence the other—is now well established in medical curricula.[18] However, 'humility' might be more realistic than 'competence' when faced with diverse and heterogeneous populations. Relatedly, there is a more recent movement for 'structural competence' to equip healthcare professionals with the tools and confidence to challenge structural inequalities.[18]

Advocacy

Current issues facing PHC often have significant political and societal overtones. Many feel ill-prepared for a role as an advocate. However, there is a long PHC history in

advocating for patients or for a community.[1 19] Advocacy recommendations include:

7. Raise awareness of issues in work and health networks and integrate these issues into teaching. Primary healthcare practitioners should get involved in community advocacy through building trust, active listening and joining established advocacy networks.[20]
8. Develop or use advocacy skills.[21] Knowledge can be developed through networks that are already working in the field or through developing research policy such as narrative and systematic reviews to summarise key findings, which can become policy recommendations. Social media or letters to the editor are another method to disseminate ideas about an issue. Paying attention to advocacy also means being attentive to 'self-care'.

Research

Critical roles in research activities are held by funders, academic journals, conferences, Institutional Review Boards and ethics committees.[20] These entities can foster SDOH-oriented PHC research. This is summarised in two actions:

9. Research conducted with a community should consider SDOH and should be centred around communities. Research teams have to co-create and address health and social inequities in their research priorities, design, approaches and collaborations.[20 22 23]
10. Prioritise collaboration and partnership with the community throughout the research process.[24] Involving the community starts with building consensus from a community perspective and asking the right questions. There should be a respectful, reciprocal and trusting relationship with the community. Outcomes and knowledge generated should be shared back to the community.[25] Key players should also ensure that research outcomes and knowledge generated through research are accessible.[22 26] For example, research conferences should commit to accessibility for community attendees and consider the accessibility of the conference venues for community attendance, particularly for communities living with disabilities and those experiencing health and social inequities.

CONCLUSION

The global primary care research community has a role in recognising the SDOH in their communities and ensuring their research encompasses an understanding of SDOH in different social settings. At the international forum of the 51st NAPCRG Annual Meeting, 10 key recommendations for addressing SDOH were developed by attendees from all over the globe. We call on the worldwide primary healthcare research community to implement these action points to lead to better health outcomes for communities.

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